

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10304

CERTIFICATE OF DEATH

10258

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Street</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rd. # 2 Box 107-A Old Forge Hill Road</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Akolaitis</u> Last <u>(Ackley)</u>				4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 24, 1878</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Vincent Juodvirsios</u>			14. MOTHER'S MAIDEN NAME <u>Lucia Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Peter F. Ackley, Rd. #2, Box 107A, Street, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u>Chronic hypertensive cardio-vascular disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. s. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 1</u> , 19 <u>59</u> , to <u>Sept. 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 9</u> , 19 <u>59</u> , and that death occurred at <u>1:25 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Willard P. Hudson M.D. Forest Hill, Md. September 10, 1959</u>							
ACTUAL SIGNATURE <u>Willard P. Hudson</u>							
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignatius Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hickory, Harford County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>				ADDRESS <u>W. Broadway + Williams St BEL Air, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH—BUTTERFIELD

DOE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10259

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Road</u>		d. STREET ADDRESS <u>Harford Road</u>	
3. NAME OF DECEASED (Type or print) <u>John S. Summerfield Bachman</u>		4. DATE <u>September 13</u> 19 <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26 1949</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md</u>
13. FATHER'S NAME <u>John S. Bachman Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Bertie B. Brandt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>John S. Bachman Sr.</u>		18. ADDRESS <u>Box 116 Harford Rd Joppa Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wounds cerebrum</u> 919.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Accidentally shot by friend with shot gun</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>3:25</u> <u>9-13</u> <u>59</u> a.m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Joppa</u> <u>Harford</u> <u>md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED <u>9-13-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 16 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Ceme</u>	22d. LOCATION (City, town, or county) (State) <u>Long Green Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Reginald Bree</u>		24a. REC'D BY REGISTRAR <u>SEP 15 '59</u>	
ADDRESS <u>7110 Belair Rd.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kins</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Death: _____

5. Place of Death: _____

6. Cause of Death: _____

7. Manner of Death: _____

8. Signature of Medical Examiner: _____

9. Signature of Coroner: _____

10. Signature of Registrar: _____

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-8. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10275

10260

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN TB 7 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Aberdeen, Maryland				e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen			
f. STREET ADDRESS 681 Plater St.				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LAWRENCE		First		Middle		Last	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/2/1917	
9. AGE (In years last birthday) 41		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH September 1, 1959	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Explosive Operator				10b. KIND OF BUSINESS OR INDUSTRY Aberdeen Paving Company			
11. BIRTHPLACE (State or foreign country) Harford County, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George H. Baeky				14. MOTHER'S MAIDEN NAME Nellie Boyd			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Mrs. Marie Baeky				Address 681 Plater St., Aberdeen, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Retroperitoneal hemorrhage DUE TO rupture of aneurysm of aorta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) 022x							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. IV		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
Address (Street, city, town, or county)				9/1/59			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9/3/59		22c. NAME OF CEMETERY OR CREMATORY Angel Hill		22d. LOCATION (City, town, or country) (State) Harford County, Md.	
23. FUNERAL DIRECTOR Barry R. Harford				24a. REC'D BY REGISTRAR SEP 4 '59			
Address Harford County, Md.				24b. REGISTRAR'S SIGNATURE Carlton L. Huns			

MEDICAL CERTIFICATION

1

THE NATIONAL BUREAU OF INVESTIGATION
UNITED STATES DEPARTMENT OF JUSTICE

Wm. J. C. [Signature]

Special Agent in Charge

Chicago, Ill. [Signature]
[Signature]
[Signature]

1935

Chicago, Ill. [Signature]
[Signature]
[Signature]

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURDE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hospital		d. STREET ADDRESS Cokesbury	
3. NAME OF DECEASED (Type or print) Helen O. BANKS		4. DATE OF DEATH Sept 5 1959	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1907
9. AGE (In years and birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses Aid		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edward L. Kell	
14. MOTHER'S MAIDEN NAME Anna R. Brown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 219-10-9177		17. INFORMANT Mrs William Rice, Havre De Grace, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Ovary 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1959 to Sept 5 1959 , that I last saw the deceased alive on Sept 5 1959 , and that death occurred at 7:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 569 Revolution St. Havre de Grace, Md. DATE SIGNED 9/5/59			
ACTUAL SIGNATURE George T. Stansbury M.D. George T. Stansbury			
PHYSICIAN'S NAME (Type) George T. Stansbury			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-8-1959	22c. NAME OF CEMETERY OR CREMATORY Cokesbury Cemetery	22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural
23. FUNERAL DIRECTOR'S SIGNATURE W. L. Patterson ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR SEP 9 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10262

10306

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. LENGTH OF STAY IN 1b <u>21 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>U.S. Army Hospital, Aberdeen Proving Ground, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>STOESSEL</u> Middle <u>SMYTHE</u> Last <u>BARKSDALE</u>		4. DATE OF DEATH Month <u>September</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>24 Feb 1905</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier - Colonel</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>1931 - 1959</u>		16. SOCIAL SECURITY NO. <u>418-01-5806</u>	
17. INFORMANT <u>Official Army Records</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>21 days</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>1 Sept</u> , 19 <u>59</u> , to <u>21 Sept</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>21 Sept</u> , 19 <u>59</u> , and that death occurred at <u>1250</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>U.S. Army Hospital, Aberdeen Proving Ground, Maryland</u>	
ACTUAL SIGNATURE <u>Joseph A. Grossman</u> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>JOSEPH A. GROSSMAN CAPT MC</u>			

22a. BURIAL, CREMATION, REMAINS (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Removal</u>	<u>9-25-59</u>	<u>Arlington National.</u>	<u>Arlington, Virginia.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook - Blight Inc. 6009 Harford Rd. Balto.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 29 59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur A. Huns</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON OFFICE

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10307

CERTIFICATE OF DEATH

10263

Reg. Dist. No.

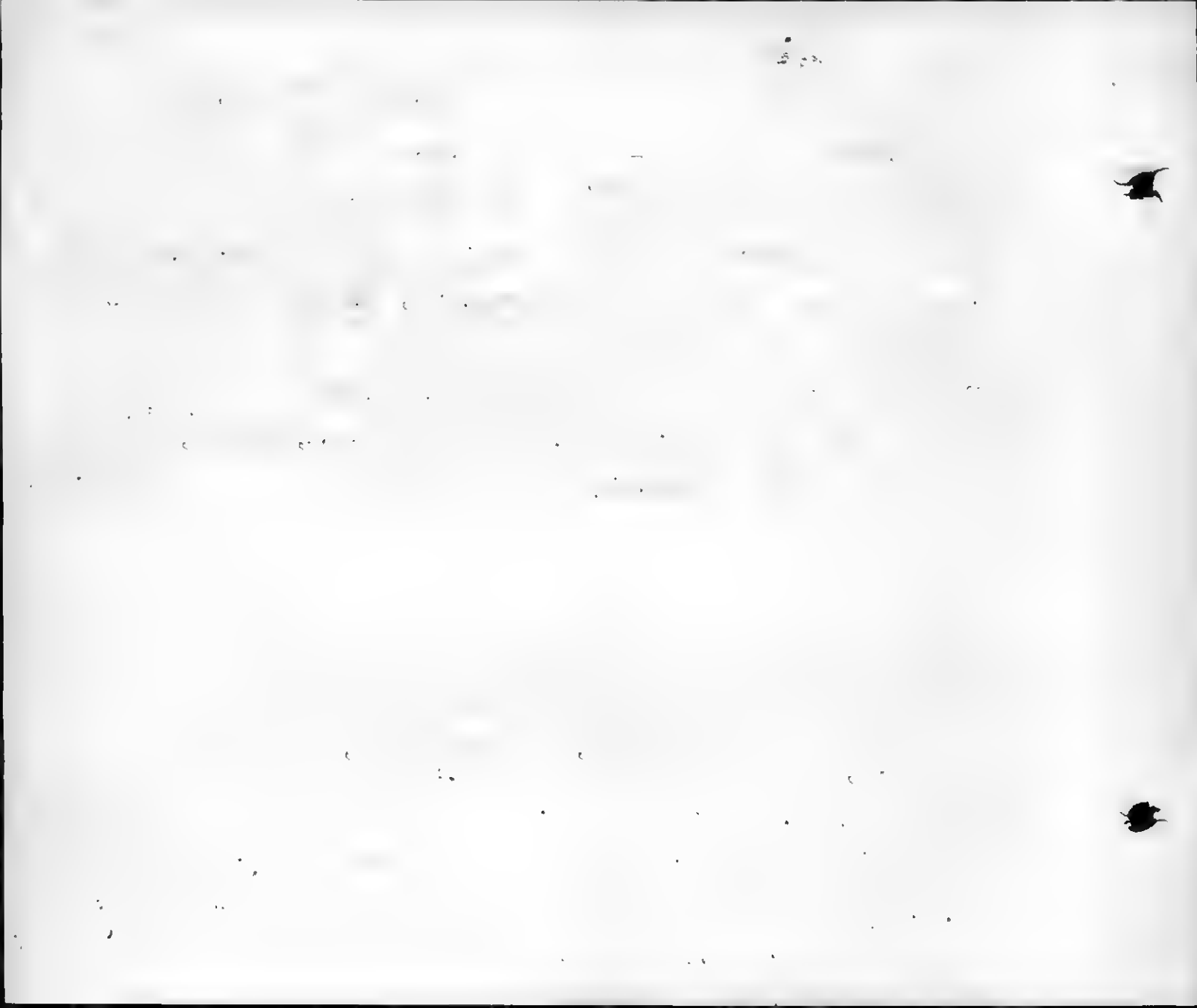
1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen c. LENGTH OF STAY IN 1b - d. NAME OF HOSPITAL (If not in hospital, give street address) US Army Hospital Aberdeen Proving Ground, Md		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood d. STREET ADDRESS 129 A Hawthorne Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EVELYN Middle BOYKIN Last BOYKIN		4. DATE OF DEATH Month September Day 2 Year 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 1, 1909
9. AGE (In years last birthday) yrs. 48		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 8 Days 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Willie Lee Boykin		14. MOTHER'S MAIDEN NAME Dezzie Dee Staten	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) N/A		16. SOCIAL SECURITY NO. None	
INFORMANT Father		Address 129 A Hawthorne Drive, Edgewood, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 8 hrs 15 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sep 1, 1959 , to Sep 2, 1959 , that I last saw the deceased alive on Sep 2, 1959 , and that death occurred at 3:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2 Sep 59			
ACTUAL SIGNATURE Alfred E Neuffer M.D.			
PHYSICIAN'S NAME (Type) ALFRED E NEUFFER CAPT MC		USAH APG Md (Harford)	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF Sep 8, 1959	22c. NAME OF CEMETERY OR CREMATORY Post Cemetery	22d. LOCATION (City, town, or county) (State) Army Chemical Center, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McNamee ADDRESS Abingdon Md		24a. REC'D BY REGISTRAR DATE SEP 10 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kneiss

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050324XV1



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10264

Reg. Dist. No.

10277

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DDA Harford Memorial Hosp.</u>		d. STREET ADDRESS <u>11 Mount St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sandra Kay Burchette</u>		4. DATE OF DEATH Month Day Year <u>September 12 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1-19-43</u>
9. AGE (in years last birthday) <u>16</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Rising Sun, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vaughn Burchette</u>		14. MOTHER'S MAIDEN NAME <u>Neva Grayson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Vaughn Burchette, Rising Sun, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull, compound</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident - auto</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7-12</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>MD Route 227 Conowingo Harford MD</u>		20f. (City or town) (County) (State) <u>Rising Sun</u> <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u> DATE SIGNED <u>9-12-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/16/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brookview</u>		22d. LOCATION (City, town, or county) (State) <u>Rising Sun</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed, Rising Sun, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 15 1959</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



10265

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD		b. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 17 hrs-40 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW BORN		Pylesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hospital				d. STREET ADDRESS Box 32-A		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Cobb				4. DATE OF DEATH Month Day Year September 12 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 12, 1959	
9. AGE (In years last birthday) 17		10. IF UNDER 1 YEAR Months Days Hours Min. 17 40		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Robert ALAN Cobb				14. MOTHER'S MAIDEN NAME RUTH RUSSELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unsanitary</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u> </u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. DATE OF CREMATION, REMOVAL OF BODY		22b. DATE THEREOF 9-12-59		22c. NAME OF CEMETERY OR CREMATORY HARFORD MEMORIAL HOSPITAL		22d. LOCATION (City, town, or county) (State) HAURE DE GRACE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Harry R. Kelly administrator				24a. REC'D BY REGISTRAR DATE SEP 17 '59		24b. REGISTRAR'S SIGNATURE <u> </u>	

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10279

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARTFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARTFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural</u>		c. LENGTH OF STAY IN 1b <u>34 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bel Air Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Amos</u> Middle <u>Oliver</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 23 - 1891</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u>	11. IF UNDER 24 HRS Hours <u>11</u> Min <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tourist Camp</u>	
11. BIRTHPLACE (State or foreign country) <u>Long Green Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Jetterson Davis</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Stewart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>264-50-0013</u>	
17. INFORMANT <u>MRS AMOS O DAVIS</u>		Address <u>Bel Air Md RD 3 Box 60</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 352X DUE TO <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 2, 1959</u> to <u>Sept 5, 1959</u> that I last saw the deceased alive on <u>Sept 5, 1959</u> and that death occurred at <u>3:45 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles Richardson</u> M.D. <u>Bel Air, Md</u>		DATE SIGNED <u>9/6/59</u>	
PHYSICIAN'S NAME (Type) <u>Charles Richardson, Jr. M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Sept 8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Long Green, Hartford, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster</u> ADDRESS <u>Bel Air Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles L. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10280

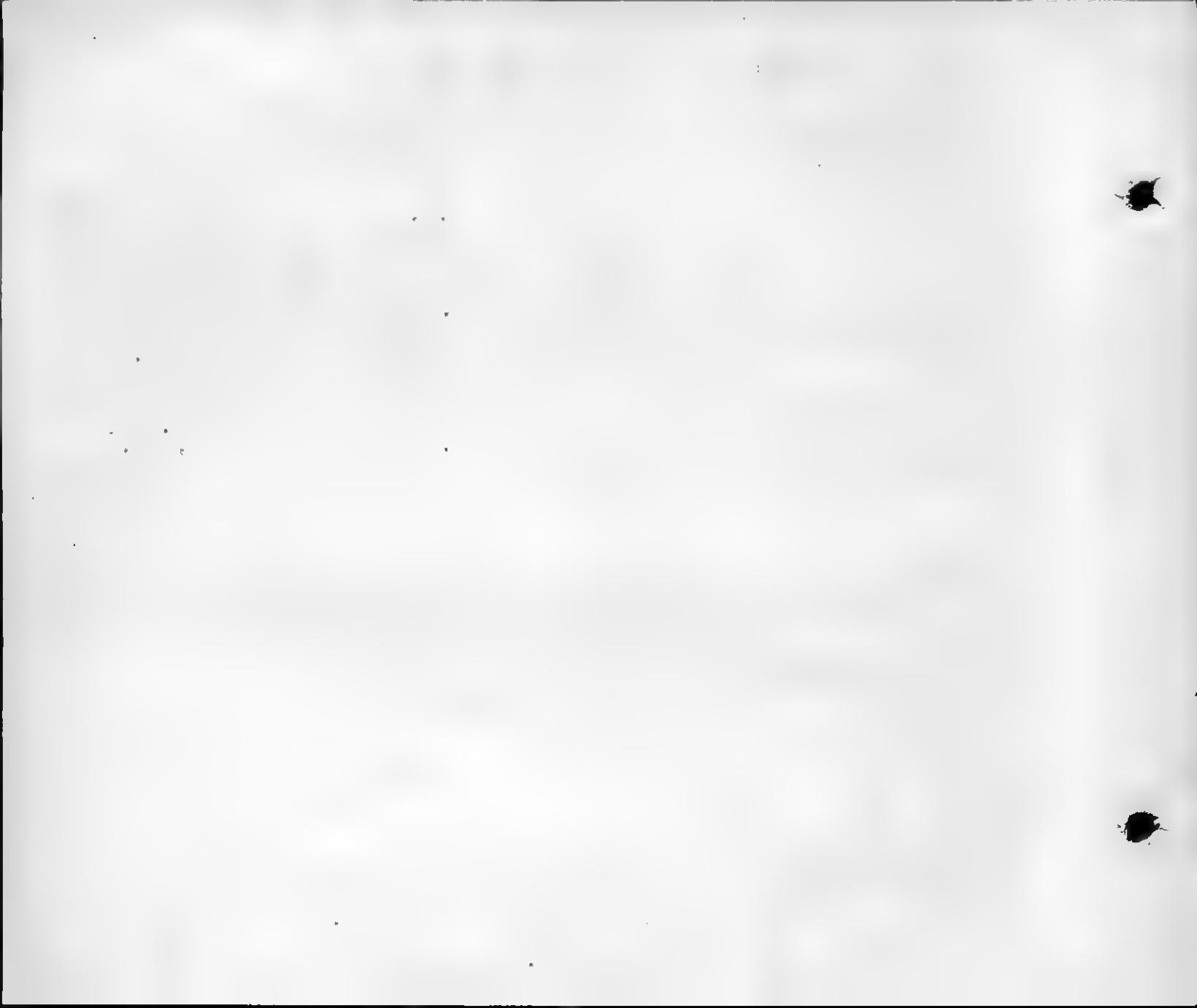
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		e. STREET ADDRESS R.D. #2	
3. NAME OF DECEASED (Type or print) First JAMES Middle MOSES Last DEAN		4. DATE OF DEATH Month September Day 14 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Feb. 1879
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Noah Dean		14. MOTHER'S MAIDEN NAME Mary Freeman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. *** **	
17. INFORMANT Robert L. Dean		Address RD. #2, Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Myocardial Infarction DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Coronary Arteriosclerosis (b) (c) INTERVAL BETWEEN ONSET AND DEATH 72 hr. 72 hr. 1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1953 , 19____, to 9-14- , 19 59 , that I last saw the deceased alive on 9-14- , 19 59 , and that death occurred at 3:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter P. Rodman M.D.		ADDRESS (Street, city or town, State) 8 Law St - Aberdeen, Md.	
DATE SIGNED 9/15/59			
PHYSICIAN'S NAME (Type) Peter P. Rodman			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/17/59	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	22d. LOCATION (City, town, or county) (State) R.D., Bel Air, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John H. Tarring		ADDRESS Tarring Funeral Home Aberdeen, Md.	
24a. REC'D BY REGISTRAR DATE SEP 21 59		24b. REGISTRAR'S SIGNATURE Robert L. Dean	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

10268

Reg. Dist. No.

10281

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>10 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>		d. STREET ADDRESS <u>351 Wilson</u>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>FISKE</u> Last <u>FORWOOD</u>		4. DATE OF DEATH Month <u>September</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 10/1899</u>
9. AGE (In years last birthday) <u>59</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tractor Operator</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John B Forwood</u>		14. MOTHER'S MAIDEN NAME <u>CARRIE V MARTIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, list or unknown) <input checked="" type="checkbox"/> (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>Mrs Kathryn C. Forwood</u>		Address <u>351 Wilson St Haver de Grace Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>422.1</u> DUE TO <u>with pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A. S. C. V. D.</u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastatic Carcinomatosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>1959</u> Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 13th, 1959</u> to <u>Sept. 23rd, 1959</u> , that I last saw the deceased alive on <u>Sept. 23rd, 1959</u> , and that death occurred at <u>6:05 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u> </u>		DATE SIGNED <u>9/23/59</u>	
PHYSICIAN'S NAME (Type) <u> </u>		ADDRESS (Street, city or town, state) <u>41 N. Union Ave. Haver de Grace, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 25/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Centre Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Forest Hill Harford Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hester Bellar</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

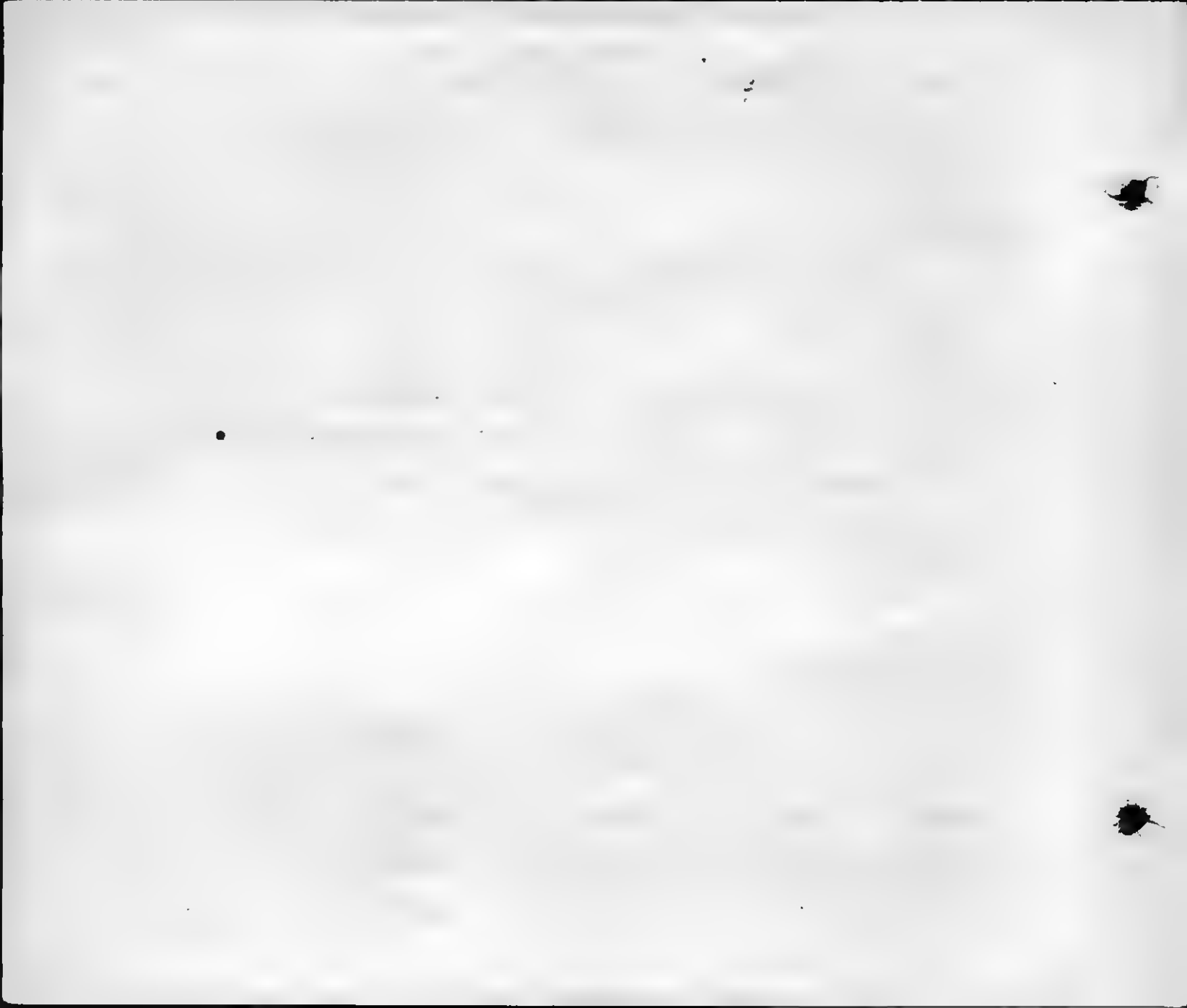
10263

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD DE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLAY'S D FREEBURGER		4. DATE OF DEATH September 8 1959	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 8/31/01	9. AGE (In years last birthday) 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME GEORGE CHAPMAN		14. MOTHER'S MAIDEN NAME Bessie Wahl	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Walter B. Freeburger,		Address Edgewood, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) approx 5 hrs. (c) Sudden			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 6th, 1959 to Sept 8th, 1959 , that I last saw the deceased alive on Sept 8th, 1959 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward C. Loo, M.D.		ADDRESS (Street, city or town, state) 211 N. Union Ave.	
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		DATE SIGNED 9/9/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 12, 1959	22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial	22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. Thomas		24a. REC'D BY REGISTRAR SEP 14 '59	
ADDRESS Abingdon, Md.,		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



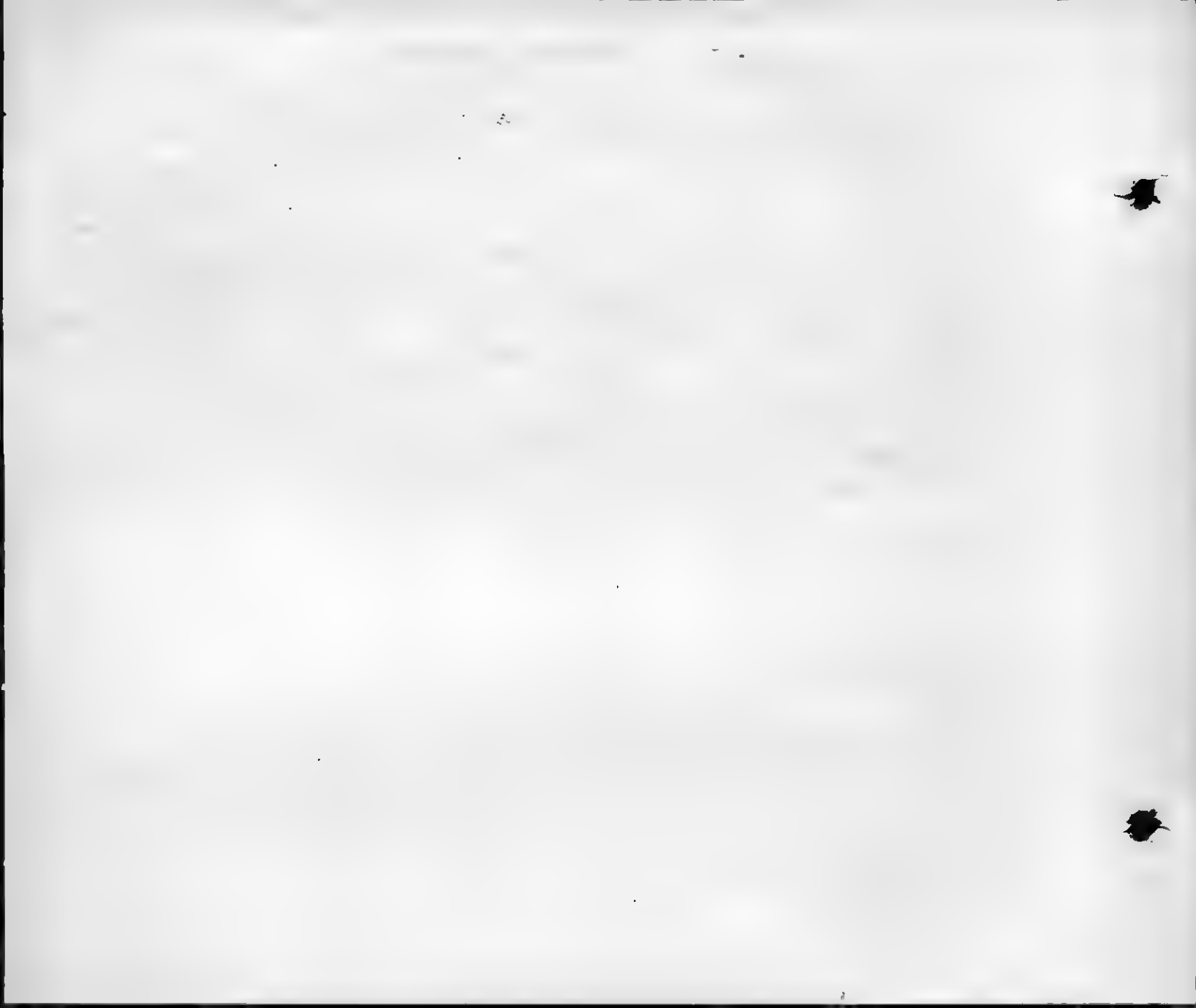
10270

Reg. Dist. No.

~~10283~~

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>118 St. John St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hannah</u> First <u>Galloway</u> Middle <u>L</u> Last		4. DATE OF DEATH Month <u>Sept.</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 12, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Harre de Grace, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Alfred Durbin</u>		14. MOTHER'S MAIDEN NAME <u>Mary Martin</u>	
15. WAS DECEASED EVER ON U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Mr. Joseph Durbin - Harre de Grace</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u>Arteriosclerotic Heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 8</u> , 19 <u>59</u> , to <u>Sept. 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 17</u> , 19 <u>59</u> , and that death occurred at <u>2:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		DATE SIGNED <u>9/19/59</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) <u>569 Revolution St. Harre de Grace, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Sept. 21, 1959</u>	<u>St. James A.M.E. Ch.</u>	<u>Harre de Grace, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Bullock</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 22 '59</u>	
ADDRESS <u>Harre de Grace, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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15M 10/57



10284

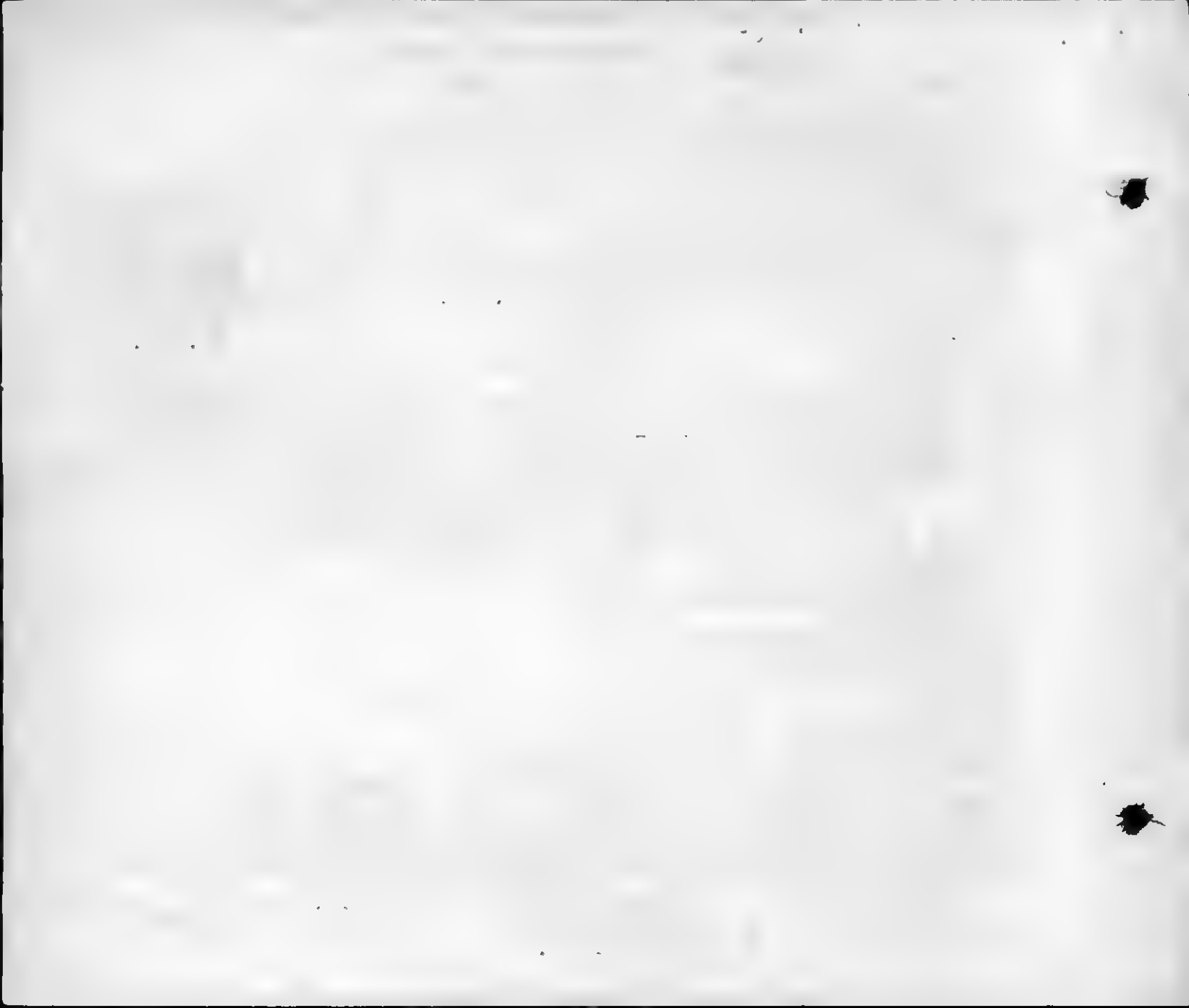
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Hartford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Hartford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hartford-Grace</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hartford Memorial Hospital</i>				d. STREET ADDRESS <i>1306 S. Philadelphia Rd.</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Warren Gardner Garey</i>				4. DATE OF DEATH Month Day Year <i>9 13 1959</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 16, 1911</i>	9. AGE (In years last birthday) yrs. <i>48</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chef</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John W. Garey</i>				14. MOTHER'S MAIDEN NAME <i>Alice Buchanan</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>383-01-5598</i>		17. INFORMANT <i>Thomas B. Garey</i> Address <i>313 Hopkins Rd. Pikesville</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Passive Congestive HF</i> 42 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Myocarditis</i> DUE TO (c) <i>2 yrs</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bilateral Pneumonia - Chronic Pericarditis</i>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept 7, 1959</i> , to <i>Sept 13, 1959</i> , that I last saw the deceased alive on <i>Sept 13, 1959</i> , and that death occurred at <i>3:40 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Ralph Horky</i> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <i>Churchwell G. Sept 14</i>			
PHYSICIAN'S NAME (Type) <i>J. Ralph Horky MD</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/16/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Bakers Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>R.D. Aberdeen Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Tarring</i> ADDRESS <i>Tarring Funeral Home Aberdeen, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>SEP 21 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kneiss</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

10285

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10272
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
c. LENGTH OF STAY IN 1b <u>17 hrs.</u>		d. STREET ADDRESS <u>190 Mayflower Restaurant</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Steve</u> Middle <u>GLAROS</u> Last <u>GLAROS</u>		4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 20, 1907</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chef</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>Alexander, Egypt</u>		12. CITIZEN OF WHAT COUNTRY? <u>Egypt</u> ✓	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>097-09-0714</u>	
17. INFORMANT <u>Pete Mavrelis</u>		Address <u>306 S. Phila. Blvd. Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gas-tri-intestinal Hemorrhage</u> <u>543X</u> DUE TO <u>Acute Hemorrhagic Gastritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2.4 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of the Liver</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/16</u> , 19 <u>59</u> , to <u>9/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/17</u> , 19 <u>59</u> , and that death occurred at <u>11:50</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. H. Sadowsky</u> M.D.		ADDRESS (Street, city or town, state) <u>504 Lewis St. Harford, Md.</u>	
PHYSICIAN'S NAME (Type) <u>H. H. SADOWSKY</u>		DATE SIGNED <u>9/17/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/20/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>R.D. Aberdeen, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Tarring</u> ADDRESS <u>Tarring Funeral Home, Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 22 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Celine E. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10308

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Woodley Farm</u>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u> d. STREET ADDRESS <u>Woodley Farm</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pora</u> Middle <u>Tasco</u> Last <u>Harris</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>16th</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2, 1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel E. Tasco</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>- - -</u>	
17. INFORMANT <u>Mary A. Hollingsworth</u> Address <u>Box 56 Perryman</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>440X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) <u>Hypertensive-Atherosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/14</u> , 19 <u>59</u> , to <u>9/15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/15</u> , 19 <u>59</u> , and that death occurred at <u>2:30 p.m.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>George J. Stansbury</u> M.D.		569 Revolution St. Harford County, Md. 9/18/59	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/19/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ashbury Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Lorley, Balto. County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Harring - Aberdeen Maryland</u> ADDRESS		24a. REC'D BY REGISTRAR <u>SEP 22 1959</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

10274

10285

1. PLACE OF DEATH COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>Charles Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORDELIA MAE HORNBERGER</u>		4. DATE OF DEATH Month Day Year <u>SEPTEMBER 7 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/24/98</u>
9. AGE (In years lost birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>0</u> <u>0</u> <u>0</u> <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS CHAMBERLAIN</u>		14. MOTHER'S MAIDEN NAME <u>Annabelle Campbell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>J. Walter Hornberger</u>		Address <u>Perryville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Acidosis</u> <u>260X</u> DUE TO <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Vascular thrombosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 19th, 1959</u> to <u>Sept. 7th, 1959</u> , that I last saw the deceased alive on <u>Sept. 7th, 1959</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Haver de Grace, Ind.</u>		DATE SIGNED <u>9/7/59</u>	
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>		PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>	
22a. BURIAL, CREMATION, REBURYAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-10-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joe L. Patterson, Jr.</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10287

CERTIFICATE OF DEATH

10275

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 21 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.		/d. STREET ADDRESS X STREET	
3. NAME OF DECEASED (Type or print) First ALICE Middle IOLA Last LAYE		4. DATE OF DEATH Month SEPTEMBER Day 24 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 30, 1896
9. AGE (In years last birthday) 62 yrs		IF UNDER 1 YEAR: Months 6 Days 24 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Maryland Harford Co.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert WALLACE	
14. MOTHER'S MAIDEN NAME FRANCES		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service) NO	
16. SOCIAL SECURITY NO. 216-24-3476		17. INFORMANT John Robert Laye Address 608 South Union Ave, Harford Co, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary of Spleen Fibrosis with Metastases 153.1 DUE TO to liver & lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3 35 M, from the causes and on the date stated above.	
ACTUAL SIGNATURE Frank E. Hauf		DATE SIGNED 608 South Union Ave, Harford Co, Md	
PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify)	
22b. DATE THEREOF Sept 27, 1959		22c. NAME OF CEMETERY OR CREMATORY Dublin M. Cem Harford Co, Md	
22d. LOCATION (City, town, or county) (State) Harford Co, Md		23. FUNERAL DIRECTOR'S SIGNATURE H. S. Bailey ADDRESS Washington, Md	
24a. REC'D BY REGISTRAR DATE SEP 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kinn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10276

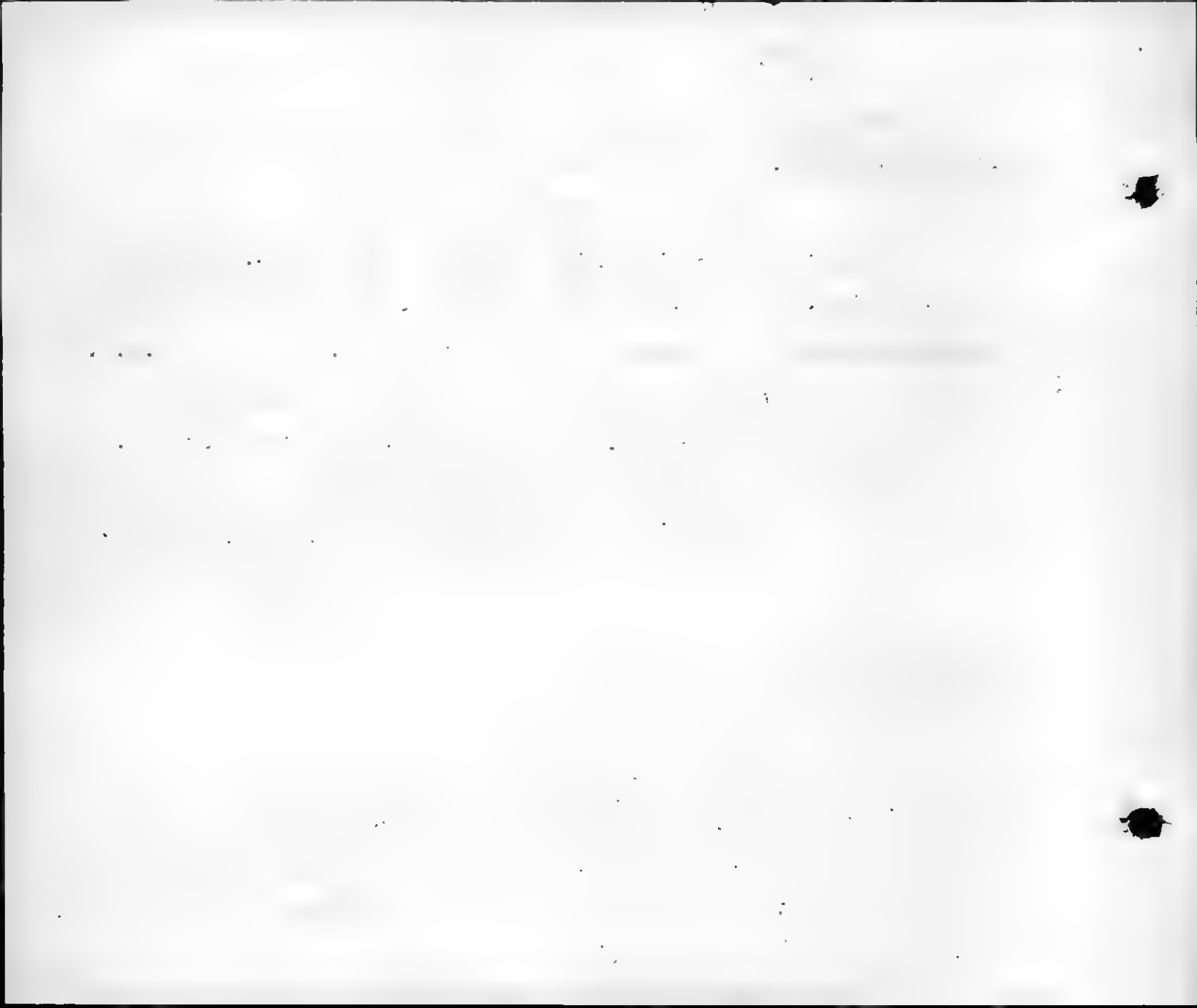
10309

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Norrisville</u> c. LENGTH OF STAY IN 1b <u>4 months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Norrisville</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAURA STANDIFORD LEMMON</u>				4. DATE OF DEATH Month Day Year <u>Sept. 28 1959</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1881</u>		9. AGE (In years last birthday) <u>78 yrs</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>				11. BIRTHPLACE (State or foreign country) <u>Monkton, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Standiford</u>						14. MOTHER'S MAIDEN NAME <u>Pierce</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>212-32-3147</u>		INFORMANT Address <u>Charles Lemmon Fallston, Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral arterial thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis generalizd.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>15 yrs</u>															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that I attended the deceased from <u>9-26</u> , 19 <u>59</u> , to <u>9-28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-26</u> , 19 <u>59</u> , and that death occurred at <u>3 P.M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>William O. Fulton</u> M.D. <u>Stewartstown, Pa.</u> DATE SIGNED _____ PHYSICIAN'S NAME (Type) <u>William O. Fulton</u>															
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/1/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>				22d. LOCATION (City, town, or county) <u>Madonna</u> (State) <u>Maryland</u>					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Charles E. Rudy Jarrettsville, Md.</u>						24a. REC'D BY REGISTRAR DATE <u>OCT 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10310

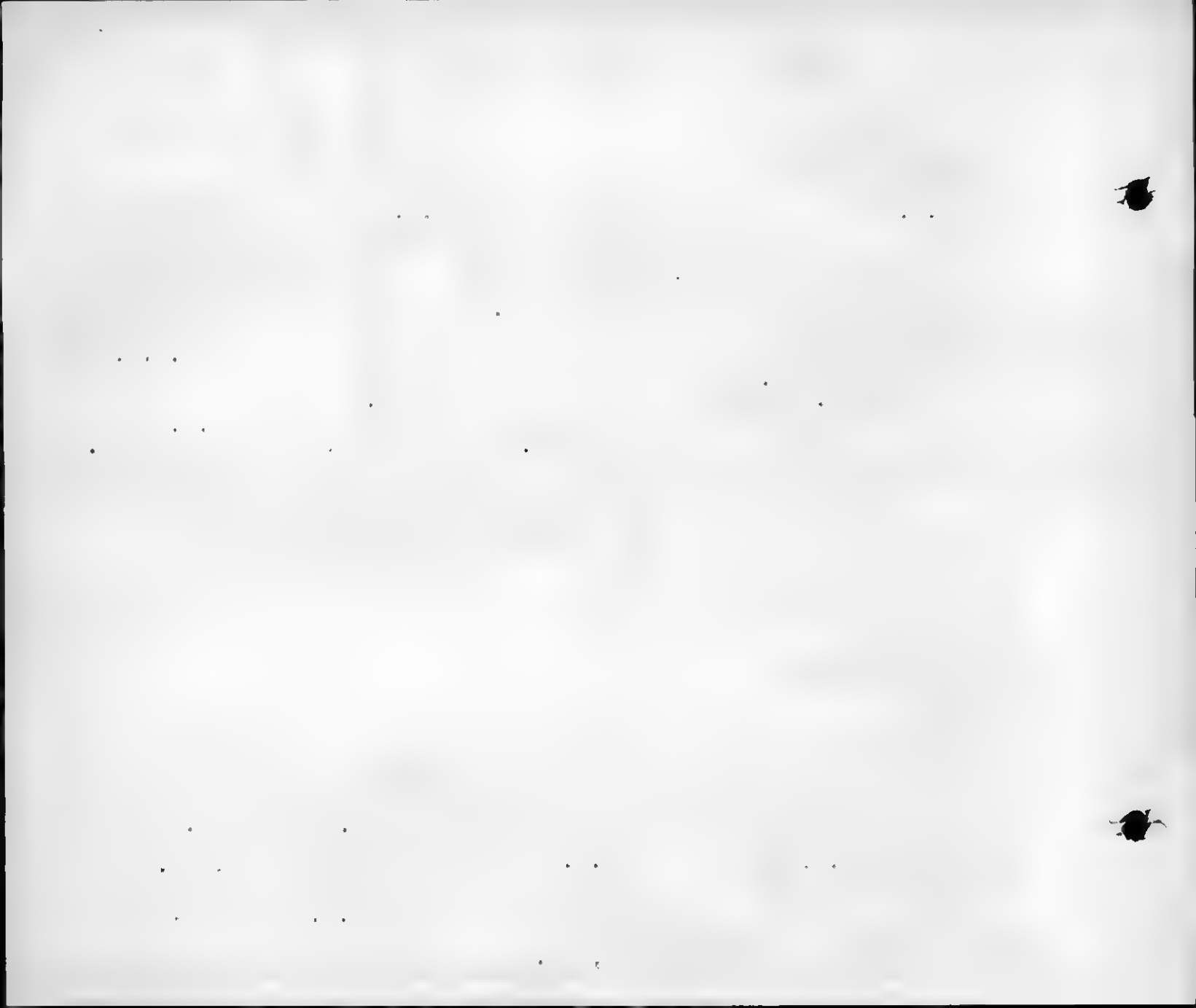
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #2		d. STREET ADDRESS R.D. #2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IDA Middle COALE Last McVEY		4. DATE OF DEATH Month September Day 26 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1876
9. AGE (In years last birthday) yrs 82		IF UNDER 1 YEAR: Months 26 Days 19 Hours 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Philip F. Coale PHILIP F. COALE		14. MOTHER'S MAIDEN NAME Ella L. Loflin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. *** **	
17. INFORMANT Mrs. Robert Payne,		Address R.D. #2 Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic nephritis - arterial Scurvy DUE TO (b) Scurvy DUE TO (c) Scurvy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/18 19 59 to Sept 26, 1959 that I last saw the deceased alive on 9-26 19 59 and that death occurred at 5:40 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE A.L. Lewis,		DATE SIGNED 9/26/59	
PHYSICIAN'S NAME (Type) A.L. Lewis,		ADDRESS (Street, city or town, state) 214 N. Union Ave.	
M.D. M.D.		DATE SIGNED 9/26/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/59	
22c. NAME OF CEMETERY OR CREMATORY Smith Chapel Cemetery		22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Tarring		24a. REC'D BY REGISTRAR DATE SEP 29 '59	
ADDRESS Aberdeen, Md.		24b. REGISTRAR'S SIGNATURE Arthur E. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10288

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lawrence Grace Rd</u>		c. LENGTH OF STAY IN 18 <u>1</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lawrence Grace Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) <u>Joseph Harry Miller</u>		4. DATE OF DEATH <u>Sept. 1 1959</u>	
5. SEX <u>Male</u> <u>White</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 22 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co Md</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>
13. FATHER'S NAME <u>James H. Miller</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Baker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, sex, age, and dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>212-26-5108</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Attack</u> <u>422.1</u> DUE TO <u>myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10</u> <u>4</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>59</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> 19 <u>58</u> to <u>Sept 1</u> 19 <u>59</u> that I last saw the deceased alive on <u>Aug 31</u> 19 <u>59</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. P. Syodgrass</u>		ADDRESS (Street, city or town, state) <u>Barlington Md</u> DATE SIGNED <u>9/3/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Lindquist</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Sept 4, 1959</u>	<u>Reshyan Chapel</u>	<u>Harford Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. D. Bailey</u>		24. REC'D BY REGISTRAR <u>SEP 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>

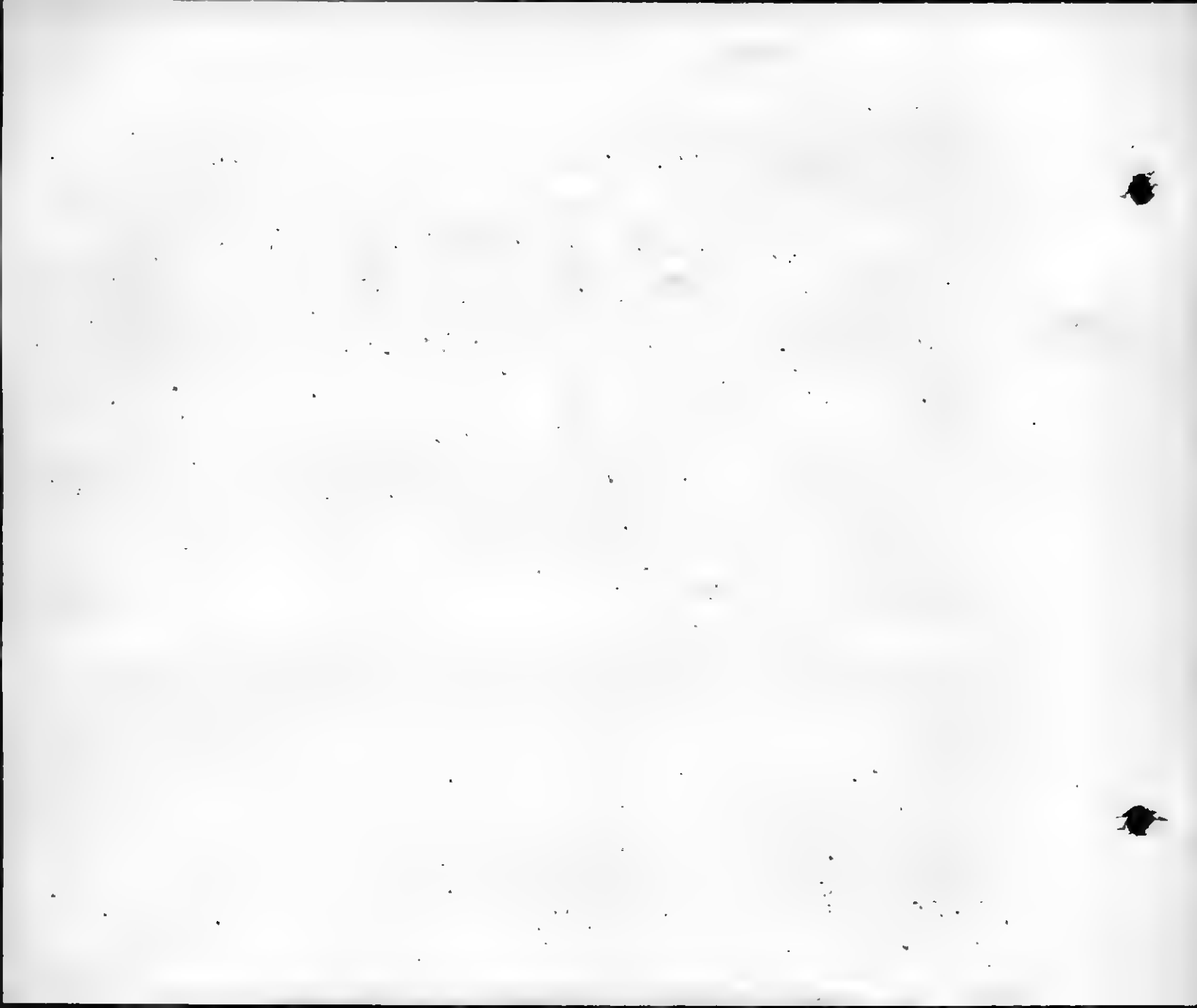
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10279

Reg. Dist. No.

10289

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colona</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Cleveland</u> Last <u>Mills</u>				4. DATE OF DEATH Month <u>September</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 23 1886</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Taylor Mills</u>				14. MOTHER'S MAIDEN NAME <u>Jane Mills</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Maltida Mills, Colona Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2 SW L. Chest</u> 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with pistol</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9-25</u> p. m. <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Colona Cecil Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Lorald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md</u>		DATE SIGNED <u>9-28-59</u>			
EXAMINER'S NAME (Type) <u>Gerold C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/30/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Darlington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Darlington Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed, Rising Sun Md</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>SEP 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>		

MEDICAL CERTIFICATION

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10280

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> 10290 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>1812</u>			
3. NAME OF DECEASED (Type or print) <u>Betty Jean Morrison</u>				4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 24 - 1942</u>	9. AGE (In years last birthday) <u>16</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boone, NC</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>			
13. FATHER'S NAME <u>Odin J. Wilcox</u>			14. MOTHER'S MAIDEN NAME <u>Fay Stevens Bel Air, MD</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs. Fay Nelson Bel Air MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO (b) <u>Fracture Tibia, compound</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> a.m. <u>9-6</u> p.m. <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bel Air Harford MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, MD</u> DATE SIGNED <u>9-10-59</u>				
EXAMINER'S NAME (Type) <u>Gerald C Palmer - MD</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 13/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Memorial</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Archer</u>		ADDRESS <u>Benson MD</u>		24a. REC'D BY REGISTRAR <u>SEP 14 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kneass</u>				24c. LOCATION (City, town, or county) (State) <u>Fennell NC</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10281

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> 10291 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN 1b <u>not forseen</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>not forseen</u> d. STREET ADDRESS <u>1736 W. Mt St</u>			
3. NAME OF DECEASED (Type or print) <u>(Gerald) Daniel Parrotha</u> First Middle Last		4. DATE OF DEATH Month <u>September</u> Day <u>5</u> Year <u>1959</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug 7th 1883</u> 9. AGE (in years last birthday) <u>76</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u> 11. BIRTHPLACE (State or foreign country) <u>Italy</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Posquale Parrotha</u> 14. MOTHER'S MAIDEN NAME <u>Unkown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Tony P. Parrotha</u> Address <u>507 H West St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest during operation for</u> <u>584X</u> DUE TO (b) <u>stone in Common Bile Duct</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Cirrhosis liver</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, md</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9-15-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Memorial</u>		22b. DATE THEREOF <u>9/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Porttellsville, Porrua</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Darring</u> ADDRESS <u>Chesapeake, Maryland</u>		24a. REC'D BY REGISTRAR <u>SEP 21 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Tinsell</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



10292

CERTIFICATE OF DEATH

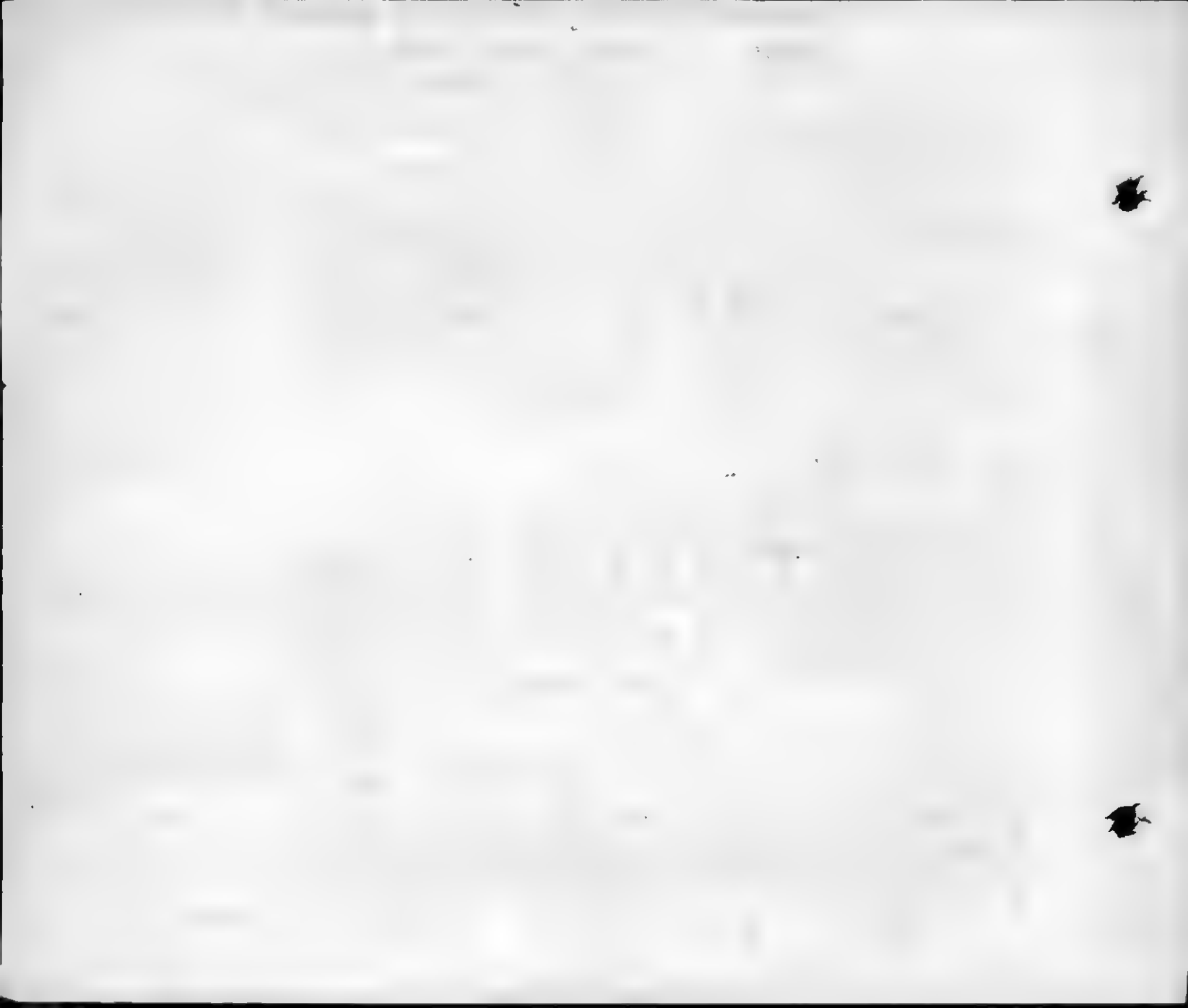
10282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD</u> c. LENGTH OF STAY IN 1b <u>HARFORD</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - RISING SUN</u> d. STREET ADDRESS <u></u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SAUL POWERS</u>				4. DATE OF DEATH Month Day Year <u>September 22 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2/9/12</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAINTING</u>		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ARTHUR POWERS</u>				14. MOTHER'S MAIDEN NAME <u>OLIVE MCCLURE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforated esophageal ulcer</u> DUE TO (b) <u>Cirrhosis of liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Coronary Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 yrs.</u> <u>2 days</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>9/18</u> , 19 <u>59</u> , to <u>9/22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/22</u> , 19 <u>59</u> , and that death occurred at <u>3:15</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rising Sun, Md.</u> DATE SIGNED <u>9/23/59</u> SIGNATURE <u>Neil Taylor</u> M.D. PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THE <u>9/25/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OXFORD CEMETARY</u>	22d. LOCATION (City, town, or county) (State) <u>OXFORD PA.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ralph M Reed Rising Sun, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>SEP 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10283

10293

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 3 yrs 9 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) Oakington Road RR #22		e. STREET ADDRESS 202 Parke Street	
3. NAME OF DECEASED (Type or print) First ROGER Middle LAWRENCE Last RIDINGS		4. DATE OF DEATH Month September Day 30 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 15, 1936
9. AGE (In years last birthday) 23 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY US Army	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Millard P Ridings		14. MOTHER'S MAIDEN NAME Unknown (deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 257-50-0313	
17. INFORMANT Official Army Records		Address Aberdeen Proving Ground, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation (carbon monoxide) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 273.1 (c) undetermined		INTERVAL BETWEEN ONSET AND DEATH undetermined	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) carbon monoxide poisoning caused by hose extending from exhaust pipe to inside of car	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. unknown 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) (County) (State) Aberdeen Harford Maryland	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on DOA _____, 19____, and that death occurred at 4:41 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) US Army Hospital DATE SIGNED 30 Sep 59			
ACTUAL SIGNATURE JAMES G ZANGRILLI		M.D. US Army Hospital	
PHYSICIAN'S NAME (Type) JAMES G ZANGRILLI Capt MC		Aberdeen Proving Ground, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 10-2-59	22c. NAME OF CEMETERY OR CREMATORY Nat. Cemetery, Marietta,	22d. LOCATION (City, town, or county) (State) Georgia.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight Inc. 6009 Harford Rd. Balto. 14		24a. REC'D BY REGISTRAR OCT 5 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur J. Frank			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 10-13-59 et

10284

10294

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Powelersing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Silveretta</u> Middle <u>R.</u> Last <u>Schaub</u>				4. DATE OF DEATH Month <u>September</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1903</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stationary</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George S. Schaub</u>				14. MOTHER'S MAIDEN NAME <u>Rosa Datchatis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-05-3265</u>		17. INFORMANT <u>Raymond Hooker, Abingdon, Maryland.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma lung</u> DUE TO <u>1 x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1959</u> to <u>Sept 11, 1959</u> , that I last saw the deceased alive on <u>Sept 9, 1959</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Bel Air, Md.</u> DATE SIGNED <u>9-11-59</u>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				PHYSICIAN'S NAME (Type) <u>Gerald C Palmer-MD</u> <u>Bel Air, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 14, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward C. McKenney</u> ADDRESS <u>Abingdon, Maryland</u>				24a. REC'D BY REGISTRAR <u>SEP 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10285

10295

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARTFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALAIR MD</u>		LENGTH OF STAY (in this place) <u>54 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALAIR</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>318 N. MAIN ST.</u>				STREET ADDRESS (If rural give location) <u>318 N. MAIN ST</u>			
3. NAME OF DECEASED (Type or Print) <u>M</u> <u>ELIA</u> <u>SHAW</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT</u> <u>3</u> <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept 1 - 1867</u>		9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refined</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Refined</u>		11. BIRTHPLACE (State or foreign country) <u>Delta Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Geo T Butler</u>				14. MOTHER'S MAIDEN NAME <u>MARY A THOMPSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or rank.) <u>✓</u> (If Yes, give war or dates of service) <u>✓</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT & ADDRESS <u>MRS. J. H. COLE</u> <u>318 N. MAIN ST BALAIR MD</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>RESPIRATORY FAILURE</u>						<u>24 HOURS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CEREBROVASCULAR ACCIDENT</u>						<u>4 WEEKS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/27</u>, to <u>1 SEPT</u>, 19<u>59</u>, that I last saw the deceased alive on <u>1 SEPT</u>, 19<u>59</u>, and that death occurred at <u>3:55</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>J. H. Cole</u>				ADDRESS (Street, city, town, state) <u>4017 Woodbury Rd</u>		DATE SIGNED <u>4 Sept 59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Sept 5/59</u>		NAME OF CEMETERY OR CREMATORY <u>Glendale Cemetery</u>		LOCATION (City, town, or county) (State) <u>Delta Pa</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. L. Kline</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster</u>		ADDRESS <u>Bel Air, Md</u>	
DATE <u>SEP 8 '59</u>							



10296

CERTIFICATE OF DEATH

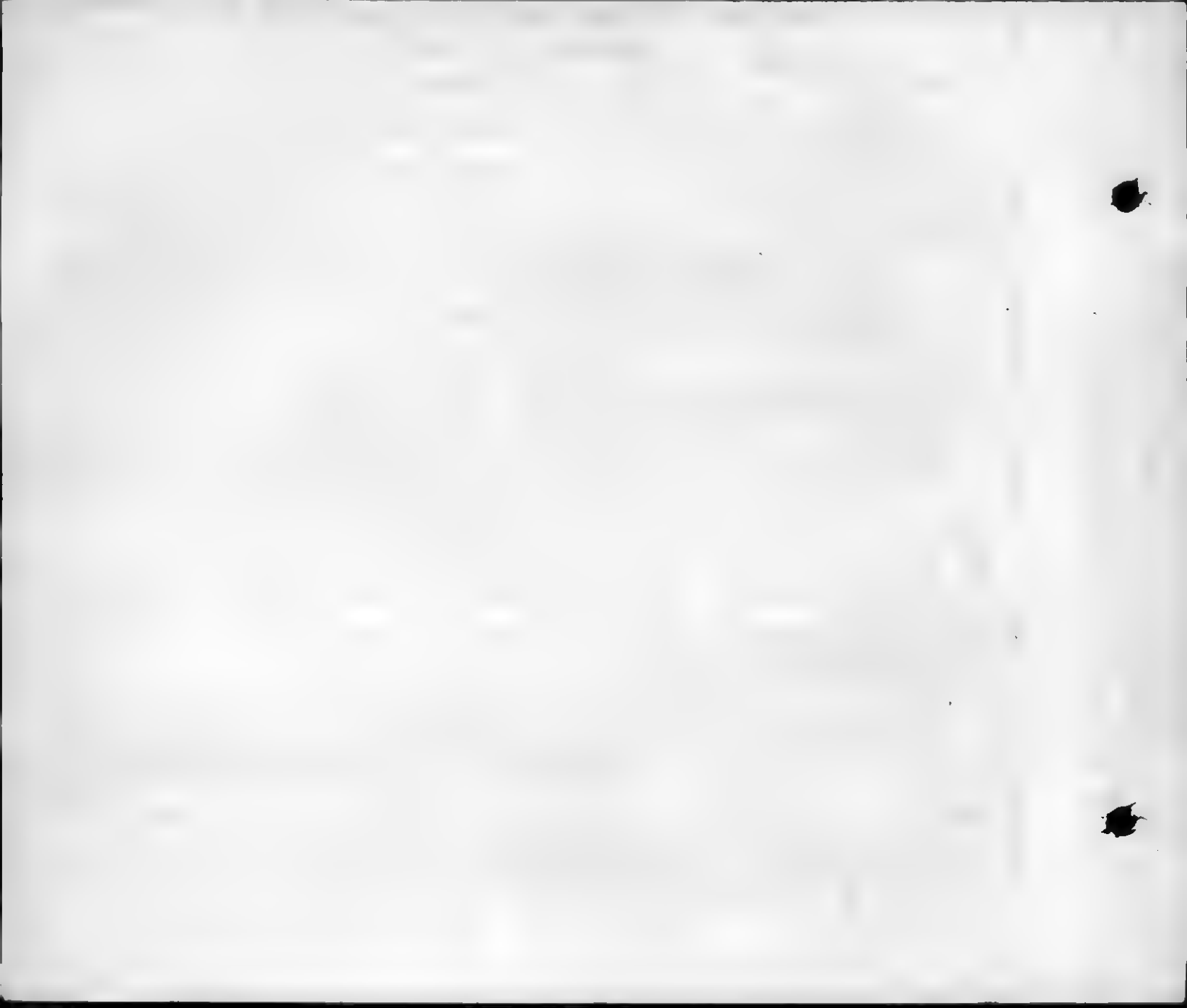
Reg. Dist. No.

10286

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission), o STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN TB <u>13 HRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Fredrick</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>September</u> Day <u>9</u> Year <u>59</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 4, 1906</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM HAND</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Smith</u>				14. MOTHER'S MAIDEN NAME <u>Rosina P.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>ANNA SMITH, PORT DEPOSIT, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Intestinal obstruction ? Peritonitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-7</u> , 19 <u>57</u> , to <u>8-7</u> , 19 <u>59</u> ; that I last saw the deceased alive on <u>8-7</u> , 19 <u>59</u> , and that death occurred at <u>12:15</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank E. Hawks</u> M.D.				ADDRESS (Street, city or town, state) <u>608 South Union Ave., Harford, Md.</u>			
DATE SIGNED <u>SEP 9 '59</u>				PHYSICIAN'S NAME (Type) <u>Arthur E. Hawks</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 9, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Delta Ridge C.</u>		22d. LOCATION (City, town, or county) (State) <u>Delta Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u>				ADDRESS <u>Delta, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hawks</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





X 1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10297 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10288

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>VOA Harford Memorial Hospital</u>		e. STREET ADDRESS <u>Forest Hill</u>	
3. NAME OF DECEASED (Type or print) <u>David Stine</u>		4. DATE OF DEATH <u>September 23</u> 19 <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 8 - 1927</u>
9. AGE (In years last birthday) <u>31</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lineman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Coburn Centre Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Stine</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Auman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes Nov. 18/48 - Mar. 1949</u>		16. SOCIAL SECURITY NO. <u>184-20-0211</u>	
17. INFORMANT <u>Mrs. Jennie Stine</u>		Address <u>Coburn, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Pole fell on his head</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> <u>23</u> <u>59</u> p.m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Forest Hill Harford MD</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Donell C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Barry W</u> DATE SIGNED <u>9-23-59</u>	
EXAMINER'S NAME (Type) <u>Donell C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/26/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Millheim Centre Co. Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Neff</u>		24a. REC'D BY REGISTRAR <u>SEP 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>

MEDICAL CERTIFICATION



10298

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Lancaster</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE de GRACE</u>				c. LENGTH OF STAY IN It <u>3 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural. Kirkwood</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Minnette Belle Swisher</u>				4. DATE OF DEATH Month Day Year <u>September 9 19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 18. 1873</u>	
9. AGE (In years last birthday) <u>86</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at own home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
13. FATHER'S NAME <u>Simcon W. Swisher</u>				14. MOTHER'S MAIDEN NAME <u>Anna Pennington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mary S. Lewis</u> Address <u>201 W. Madison Baltimore</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Pulmonary edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u>				DUE TO (c) <u>3 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. [City or town] (County) (State)							
21. I certify that I attended the deceased from <u>8/15</u> , 19 <u>59</u> , to <u>9/9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/9</u> , 19 <u>59</u> , and that death occurred at <u>7:45</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.				ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u> DATE SIGNED <u>9/9/59</u>			
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr</u>				ADDRESS <u>Rising Sun, Md</u> DATE SIGNED <u>9/9/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 12. 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Pres. Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Kirkwood Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leet. Patterson & Son</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>SEP 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Haud</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

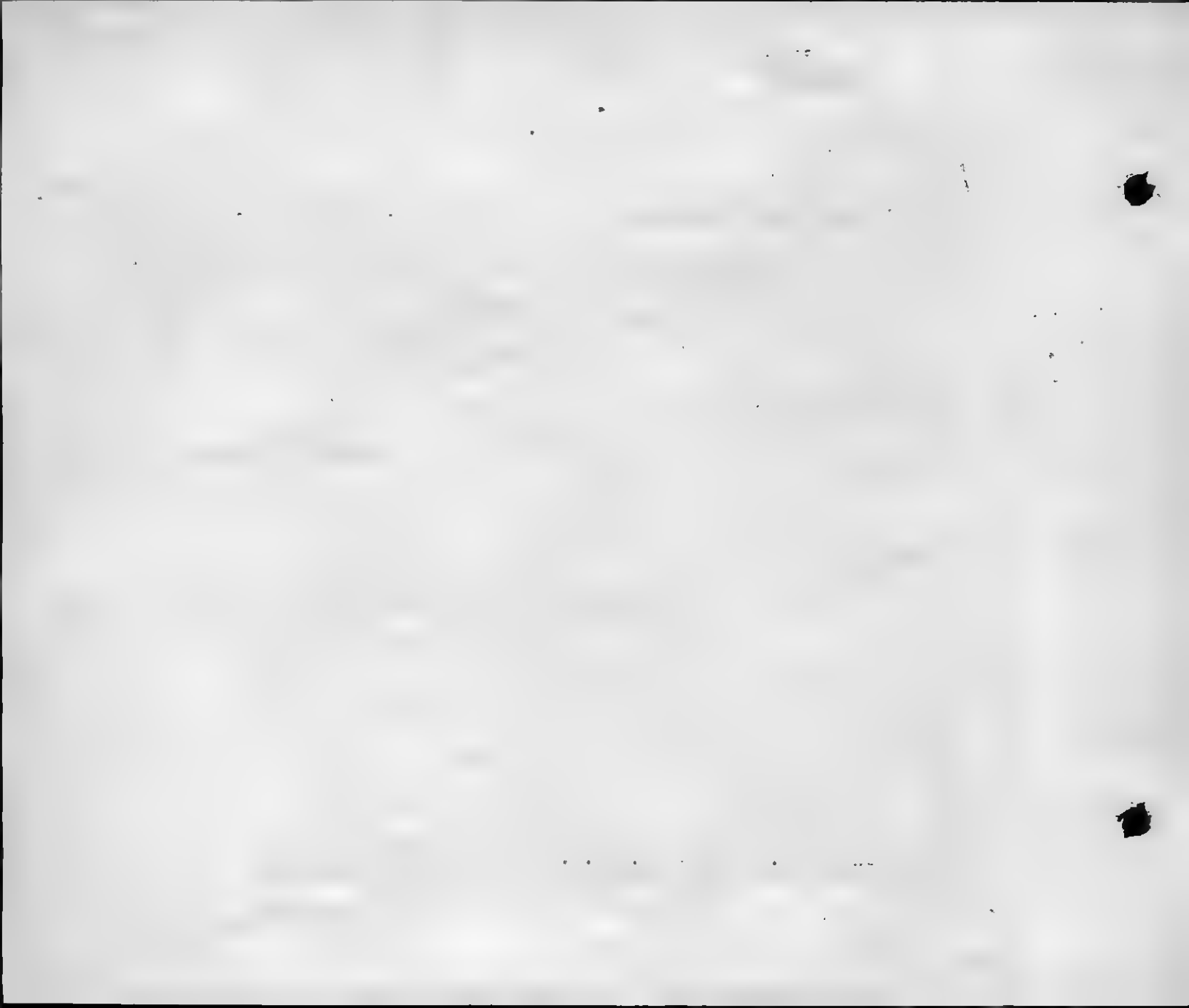
VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

tem 18 Film 251

11-3-59
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 31 Aberdeen	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Harford Memorial Hospital		e. STREET ADDRESS Level, Aberdeen, Md.	
3. NAME OF DECEASED (Type or print) JOSEPH LEE TAYLOR		4. DATE OF DEATH September 18, 1959	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APR 14 1957	
9. AGE (In years last birthday) 2		10. IF UNDER 1 YEAR Months 2 Days 18 Hours 15 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Joseph L Taylor		14. MOTHER'S MAIDEN NAME Dorothy Ackar	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. RD 2-Box 17A	
17. INFORMANT Joseph L Taylor		Address Street Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple ulceration of skin and subcutaneous tissue. 715X DUE TO Conditions, if any, which gave rise to immediate cause (b) 715X (a), stating the underlying cause last. (c) 715X DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DATE SIGNED 9/19/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Sept 21 1959	
22c. NAME OF CEMETERY OR CREMATORY Oak Grove Baptist		22d. LOCATION (City, town, or country) (State) Schuck's Corner Harford Md	
23. FUNERAL DIRECTOR Joseph J. Lister Bel Air Md		24a. REC'D BY REGISTRAR DATE SEP 22 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Kram			



10300

CERTIFICATE OF DEATH

10291

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>215 D. Washington</u>	
3. NAME OF DECEASED (Type or print) <u>Theodosia Kelly French</u>		4. DATE OF DEATH <u>9/14/59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/14/1871</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles R. Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Ella Amanda Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Joseph H. Gibson</u>		18. ADDRESS <u>215 D. Washington Harford Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Insufficiency</u> DUE TO <u>Large Cystic Hypertrophy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Large Cystic Hypertrophy</u> (c) <u>Large Cystic Hypertrophy</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/10/59</u> , 19 <u>59</u> , to <u>9/14/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/10/59</u> , 19 <u>59</u> , and that death occurred at <u>Md</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. L. Lewis</u> M.D.		DATE SIGNED <u>SEP 18 59</u>	
PHYSICIAN'S NAME (Type) <u>A. L. Lewis M.D.</u>		ADDRESS <u>244 N. Union Ave - Harford, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9/17/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harford Md</u>		24a. REC'D BY REGISTRAR <u>SEP 18 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10301 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 11, 12 File 249 9-24-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>Mount St</u>	
3. NAME OF DECEASED (Type or print) First <u>Sandra</u> Middle <u>Tressler</u> Last <u>Tressler</u>		4. DATE OF DEATH Month <u>September</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 14, 1943</u>
9. AGE (In years last birthday) <u>15</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Bethlehem, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Irwin Tressler</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Morgan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Isabelle Tressler</u>		Address <u>Rising Sun</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull, compound</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO (a) <u> </u> (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Auto accident auto-auto type</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>5</u> P. M. <u>9-12-59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>MD Route 222</u>		20f. (City or town) (County) (State) <u>Conowingo Cecil Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerard C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <u>B. A. C. M.</u> DATE SIGNED <u>9-13-59</u>	
EXAMINER'S NAME (Type) <u>Gerard C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/16/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brookview</u>		22d. LOCATION (City, town, or county) (State) <u>Rising Sun Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed, Rising Sun Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



10293

10218 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10312

Item 4 File # G248 9-11-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Larford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.D. Joppa</u>		c. LENGTH OF STAY IN IB <u>3 Years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mountain Road</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa R.D.</u>	
3. NAME OF DECEASED (Type or print) <u>Richard Edward Tudor</u>		4. DATE OF DEATH <u>September 16, 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIAGE <u>WIDOWED</u>	8. DATE OF BIRTH <u>Estimated 1897</u>
9. AGE (in years last birthday) <u>62 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>213-20-5589</u>	
17. INFORMANT <u>Mrs. Mrs. Joseph Tudor</u>		Address <u>Joppa, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Herald C Palmer</u>		DATE SIGNED <u>9-9-59</u>	
EXAMINER'S NAME (Type) <u>Herald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>North Green Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>North Green Harford Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph L. Lister Bel Air Md</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 8 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles R. Hume</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



10302

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>		e. STREET ADDRESS <u>R.D. #3, Box 90</u>	
3. NAME OF DECEASED (Type or print) First <u>ORVILLE</u> Middle <u>H.</u> Last <u>WALTER SR.</u>		4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 24, 1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Albert Walter</u>	
14. MOTHER'S MAIDEN NAME <u>Annie Grimes</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>— — —</u>		17. INFORMANT Address <u>RD. #3,</u> <u>Mrs. Bessie Walter, Box 90, Aberdeen, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Decompensation</u> <u>451X</u> DUE TO <u>with pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Slowly perforating abdominal</u> DUE TO <u>arterial aneurysm</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>5 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Sept</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 2</u> , 19 <u>59</u> , and that death occurred at <u>840</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Sadowsky</u> M.D.		ADDRESS (Street, city or town, state) <u>504 LEWIS ST.</u>	
PHYSICIAN'S NAME (Type) <u>W. H. SADOWSKY MD</u>		DATE SIGNED <u>9/2/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/6/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Smith Chapel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>R.D. Aberdeen, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Tarring</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 8 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

FILE NO.

DATE OF DEATH

DECEASED

RESIDENT OF

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DIAGNOSIS

DATE OF DEATH

PLACE OF DEATH

NAME OF PHYSICIAN

DATE

[Faint, mostly illegible text in the main body of the certificate, likely containing details of the death and medical history.]

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

BOSTON, MASS.

10303

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>725 D Washington</i>	
3. NAME OF DECEASED (Type or print) <i>Nettie Mahan Walters</i>		4. DATE OF DEATH <i>9/17/59</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/24/1893</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	9. AGE (In years last birthday) <i>66</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Charles G. Mahan</i>		14. MOTHER'S MARDEN NAME <i>Sarah G. Tyson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>U.G. Walters</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Gall-bladder</i> 155.1 DUE TO <i>with liver metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>4 months</i> (c) <i>Interval between onset and death</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 30th, 1959</i> to <i>9/17th, 1959</i> that I last saw the deceased alive on <i>9/17/59</i> , 1959 and that death occurred at <i>8 P. M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>211 N. Union Ave. Harford, Md.</i>	
ACTUAL SIGNATURE <i>Edward C. Foo, M.D.</i>		DATE SIGNED <i>9/19/59</i>	
PHYSICIAN'S NAME (Type) <i>Edward C. Foo, M.D.</i>		ADDRESS <i>Harford, Md.</i>	
22. BURIAL, CREMATION, REMOVAL (Specify) <i>9/20/59</i>		22c. NAME OF CEMETERY OR CREMATOR <i>Angel Hill</i>	
22d. LOCATION (City, town, or county) (State) <i>Harford, Md.</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>William J. ...</i>	
24a. REC'D BY REGISTRAR <i>SEP 22 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Frank</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED
NAME
AGE
SEX
RACE
BORN
DIED

Place of Birth		Date of Birth	
Place of Death		Date of Death	
Cause of Death		Manner of Death	
Occupation		Usual Residence	
Signature of Physician		Signature of Registrar	
Date		Place	